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**Ambulatory Patient Group System: Hospital-Based Outpatient**

For dates of service beginning December 1, 2008, for hospital outpatient clinic and ambulatory surgery services, and beginning January 1, 2009, for emergency department services, through March 31, [2012]2013, the operating component of rates for hospital based outpatient services shall be reimbursed using a methodology that is prospective and associated with resource utilization to ensure that ambulatory services are economically and efficiently provided. The methodology is based upon the Ambulatory Patient Group (APG) classification and reimbursement system. This methodology incorporates payments for the separate covered Medicaid benefits in accordance with the payment methods for these services. Reimbursement for the capital component of these rates shall be made as an add-on to the operating component as described in the APG Rate Computation section.

The Ambulatory Patient Group patient classification system is designed to explain the amount and type of resources used in an ambulatory visit by grouping patients with similar clinical characteristics and similar resource use into a specific APG. Each procedure code associated with a patient visit is assigned to an APG using the grouping logic developed by 3M Health Information Systems. When evaluation and management codes are coded, the APG grouping logic also uses the diagnosis code to make the APG assignment. Ultimately, the procedures and diagnoses coded for a patient visit will result in a list of APGs that correspond on a one-for-one basis with each procedure coded for the visit.

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**APG Reimbursement Methodology – Hospital Outpatient**

The following links direct users to the various definitions and factors that comprise the APG reimbursement methodology[:], which can also be found in aggregate on the APG website at http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm. In addition, prior period information associated with these links is available upon request to the Department of Health.

**[3M] Contact Information[; effective 12/1/2008]:**
[http://www.health.state.ny.us/health_care/medicaid/rates/apg/docs/contacts.pdf]
http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm Click on "Contacts."

**3M APG Crosswalk, version 3.3 [3.1, effective 7/1/09]:**
http://www.health.ny.gov/health_care/medicaid/rates/crosswalk/index.htm
http://dashboard.emedny.org/CrossWalk/html/cwAgreement.html Click on "Accept" at bottom of page to gain access.

**APG Alternative Payment Fee Schedule; updated as of 12/01/09:**
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Alternative Payment Fee Schedule."

**APG Consolidation[/Bundling;] Logic [effective 12/1/08 and last updated 7/1/09]; logic is from the version of 4/01/08, updated as of 12/01/09:**
[http://www.health.state.ny.us/health_care/medicaid/rates/apg/#apg_cons]
http://www.health.ny.gov/health_care/medicaid/rates/bundling/2008/index.htm

**APG 3M Definitions Manual Versions; [effective 12/1/08 and last] updated [7/1/09] as of 12/01/09:**
[http://www.health.state.ny.us/health_care/medicaid/rates/apg/docs/versions_with_effective_dates.xls]
http://www.health.ny.gov/health_care/medicaid/rates/crosswalk/index.htm

**APG Investments by Rate Period; updated as of 12/01/09:**
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Investments by Rate Period."

**APG Relative Weights; [effective 12/1/08] updated as of 12/01/09:**
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Weights, Proc Weights, and APG Fee Schedule Amounts" file.

**Associated Ancillaries; effective 7/01[9]/09:**
[http://www.health.state.ny.us/health_care/medicaid/rates/apg/docs/proc_subject_to_ancillary_policy.xls]
http://www.health.ny.gov/health_care/medicaid/rates/apg/index.htm Click on "Ancillary Policy."

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**Base Rates, Hospital Outpatient Clinics, effective [7/1/09] 12/01/09:**
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "APG Rates" and then "Hospital."

**Carve-outs; updated as of 12/01/09:**
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Carve Outs."

**Coding Improvement Factors (CIF); [effective 12/1/08 and] updated [7/1/09] as of 12/01/09:**
[http://www.health.state.ny.us/health_care/medicaid/rates/apg/docs/APG_CIFs_by_Rate_Period.xls]
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "CIFs by Rate Period."

**Modifiers; updated as of 12/01/09:**
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Modifiers."

**Never Pay APGs; updated as of 12/01/09:**
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Never Pay APGs."

**Never Pay Procedures; updated as of 12/01/09:**
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Never Pay Procedures."

**No-Blend APGs; [effective 12/1/08 and] updated as of 12/01/09:**
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "No Blend APGs."

**Non-50% Discounting APG List; updated as of 12/01/09:**
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Non-50% Discounting APG List."

**Uniform Packaging Ancillaries; [effective 12/1/08] updated as of 12/01/09:**
[http://www.health.state.ny.us/health_care/medicaid/rates/apg/docs/uniform_packaging_apgs.xls]
http://www.health.ny.gov/health_care/medicaid/rates/methodology/index.htm Click on "Uniform Packaging APGs."

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**Hospital-Based APG Base Rate Table**

| Peer Group | Region | Rate Start Date | Base Rate Effective [9/1/2009*] 12/1/09 |
|---|---|---|---|
| Ambulatory Surgery Services | Downstate | 12/01/08 | $156.91 |
| Ambulatory Surgery Services | Upstate | 12/01/08 | $122.55 |
| Emergency Department | Downstate | 01/01/09 | $175.11 |
| Emergency Department | Upstate | 01/01/09 | $135.27 |
| Outpatient Department/School Based Health Center (OPD/SBHC) | Downstate | 12/01/08 | [$258.90] $199.18 |
| Outpatient Department/School Based Health Center | Upstate | 12/01/08 | [$199.00] $153.11 |

[*These rates became effective on 7/1/2009, but are still in effect as of 9/1/2009.]

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**Ambulatory Patient Group System – Hospital Outpatient**

[For dates of service beginning December 1, 2008, for hospital outpatient clinic and ambulatory surgery services, and beginning January 1, 2009, for emergency department services, through March 31, 2010, the operating component of rates for hospital based outpatient services shall be reimbursed using a methodology that is prospective and associated with resource utilization to ensure that ambulatory services are economically and efficiently provided. The methodology is based upon the Ambulatory Patient Group (APG) classification and reimbursement system. This methodology incorporates payments for the separate covered Medicaid benefits in accordance with the payment methods for these services. Reimbursement for the capital component of these rates shall be made as an add-on to the operating component as described on Page 1(k) of this section.

The Ambulatory Patient Group patient classification system is designed to explain the amount and type of resources used in an ambulatory visit by grouping patients with similar clinical characteristics and similar resource use into a specific APG. Each procedure code associated with a patient visit is assigned to an APG using the grouping logic developed by 3M Health Information Systems. When evaluation and management codes are coded, the APG grouping logic also uses the diagnosis code to make the APG assignment. Ultimately, the procedures and diagnoses coded for a patient visit will result in a list of APGs that correspond on a one-for-one basis with each procedure coded for the visit.]

**The following is a list of definitions relating to the Ambulatory Patient Group reimbursement system.** Links to detailed APG Reimbursement Methodology lists are located in the APG Reimbursement Methodology - Hospital Outpatient section.

**Allowed APG Weight** shall mean the relative resource utilization for a given APG after adjustment for bundling, packaging, and discounting.

**Ambulatory Patient Group (APG)** shall mean a group of outpatient procedures, encounters or ancillary services, which reflect similar patient characteristics and resource utilization and which incorporate the use of ICD-9-CM diagnosis and HCPCS procedure codes, as defined below. APGs are defined under 3M Health Information Systems' grouping logic outlined in the APG Definitions Manual. A link to the APG Definitions Manual[s] versions and effective dates is available in the APG Reimbursement Methodology - Hospital Outpatient section.

**APG Relative Weight** shall mean a numeric value that reflects the relative expected average resource utilization (cost) for each APG as compared to the expected average resource utilization for all other APGs. A link to the APG relative weights for all periods is available in the APG Reimbursement Methodology- Hospital Outpatient section.

**Associated Ancillaries** shall mean laboratory and radiology tests and procedures ordered in conjunction with an APG visit. A link to the list of associated ancillaries for all periods is available in the APG Reimbursement Methodology - Hospital Outpatient section.

**APG Software** shall mean the New York State-specific version of the APG computer software developed and published by [(]3M[)] Health Information Systems, Inc. (3M) to process HCPCS/CPT-4 and ICD-9-CM code information in order to assign patient visits, at the procedure code level, to the appropriate APGs and apply appropriate bundling, packaging, and discounting logic to in turn calculate the final APG weight and allowed reimbursement for a patient visit. Each time the software is updated, 3M [HIS] will automatically send updated software to all license holders. Providers and other interested parties that do not purchase the grouper software[,] can perform the computations by accessing the APG definitions manual, which is available on the 3M web site.

**Base Rate** shall mean the dollar value that shall be multiplied by the allowed APG weight for a given APG, or by the final APG weight for each APG on a claim to determine the total allowable Medicaid operating payment for a visit.

**Carve-outs** shall mean certain procedures which are not paid using the APG reimbursement methodology. Procedures that are not payable in APGs may be reimbursed through the NYS Medicaid ordered ambulatory fee schedule or the dental fee schedule for orthodontia only. If the procedure is not reimbursable thru the APG methodology or on the fee schedules as stated, they are not reimbursable in Medicaid. The NYS Medicaid fee schedules are provided on the eMedNY website under provider manuals.

**Case Mix Index** is the actual or estimated average final APG weight for a defined group of APG visits.

**Coding Improvement Factor** is a numeric value used to adjust for more complete and accurate coding for visits upon implementation of the APG reimbursement system. A link to the coding improvement factors for all periods is available in the APG Reimbursement Methodology - Hospital Outpatient section.

**Consolidation/Bundling** shall mean the process for determining if a single payment amount is appropriate in those circumstances when a patient receives multiple APG procedures during a single patient visit. In some cases, a procedure will be considered part of a more complicated procedure. In this case the payment for the less complicated procedure will be included in the payment for the more complicated procedure and the claim line for the less complicated procedure will show zero payment for that procedure. Consolidation logic is defined in the 3M Health Information Systems' APG Definitions Manual, a link to which is provided in the APG Reimbursement Methodology - Hospital Outpatient section.

**Current Procedural Terminology-fourth edition (CPT-4)** is the systematic listing and coding of procedures and services provided by physicians or other related health care providers. It is a subset of the Healthcare Common Procedure Coding System (HCPCS). The CPT-4 is maintained by the American Medical Association and the HCPCS [are] is maintained by the Centers for Medicare and Medicaid Services. Both coding systems are updated annually.

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**Discounting** shall mean the reduction in APG payment that results when related procedures or ancillary services are performed during a single patient visit. Discounting [is always] will be at the rate of 50% until January 1, 2010, with the exception of those discounts listed in the link to the Non-50% Discounting APG List provided in the APG Reimbursement Methodology – Hospital Outpatient Section.

**Final APG Weight** shall mean the allowed APG weight for a given visit as calculated by the APG software using the logic in the APG definitions manual, including all adjustments applicable for bundling, packaging, and discounting.

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**"HCPCS Codes"** are from the Healthcare Common Procedure Coding System, a numeric coding system maintained by the Centers for Medicare and Medicaid Services (CMS) and used to identify services and procedures for purposes of billing public or private health insurance programs. CPT (Common Procedure Terminology) codes are a subset of the HCPCS coding system.

**International Classification of Diseases, 9th Revision-Clinical Modification (ICD-9-CM)** is a comprehensive coding system maintained by the federal Centers for Medicare and Medicaid Services in the US Department of Health and Human Services. It is maintained for the purpose of providing a standardized, universal coding system to identify and describe patient diagnosis, symptoms, complaints, condition and/or causes of injury or illness. It is updated annually.

**Modifier** shall mean a HCPCS Level II code used in APGs, based on its meaning in the HCPCS lexicon, to modify the payment for a specific procedure code or APG.

**Never Pay APGs** shall mean an APG where all the procedure codes that map to the APG are carved out of APGs and will not be paid using the APGs reimbursement methodology. Procedures that are not payable in APGs may be reimbursed through the NYS Medicaid ordered ambulatory fee schedule or the dental fee schedule for orthodontia only. The Never Pay APG file details if there is an alternative payment available. If an alternative payment is available, providers should review the NYS Medicaid fee schedules as stated to determine the payment. The NYS Medicaid fee schedules are provided on the eMedNY website under provider manuals.

**Never pay procedures** shall mean procedure codes that are carved out of APGs and will not be paid using the APGs reimbursement methodology. Procedures that are not payable in APGs may be reimbursed through the NYS Medicaid ordered ambulatory fee schedule or the dental fee schedule for orthodontia only. The Never Pay Procedures file details if there is an alternative payment available. If an alternative payment is available, providers should review the NYS Medicaid fee schedules as stated to determine the payment. The NYS Medicaid fee schedules are provided on the eMedNY website under provider manuals.

**No-blend APG** shall mean an APG that has its entire payment calculated under the APG reimbursement methodology without regard to the historical average operating payment per visit for the provider. A link to a list of no-blend APGs for all periods is available in the APG Reimbursement Methodology - Hospital Outpatient section.

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**Packaging** shall mean those circumstances in which payment for routine ancillary services or drugs shall be deemed as included in the applicable APG payment for a related significant procedure or medical visit. Medical visits also package with significant procedures, unless specifically excepted in regulation. There is no packaging logic that resides outside the software. A link to a list of the uniform packaging APGs for all periods is available in the APG Reimbursement Methodology - Hospital Outpatient section.

**"Peer Group"** shall mean a group of providers or services that share a common APG base rate. Peer groups may be established based on a geographic region, service type, or categories of patients. The six hospital peer groups are outpatient department/school-based health center - upstate, outpatient department/school-based health center - downstate, ambulatory surgery - upstate, ambulatory surgery - downstate, emergency department - upstate, and emergency department - downstate.

**"Procedure-based Weight"** shall mean a numeric value that reflects the relative expected average resource utilization (cost) for a given HCPCS/CPT code as compared to the expected average resource utilization for other HCPCS/CPT codes or APGs. If a procedure code has not been assigned a procedure-based weight, the APG relative weight for the APG to which that procedure code groups will be used as the basis for reimbursement for that procedure code (subject to the consolidation, discounting and packaging logic).

**"Region"** shall mean the counties constituting a peer group that has been defined, at least in part, on a regional basis. The downstate region shall consist of the five counties comprising New York City, as well as the counties of Nassau, Suffolk, Westchester, Rockland, Orange, Putnam, and Dutchess. The upstate region shall consist of all other counties in New York State.

**"APG Visit"** shall mean a unit of service consisting of all the APG services and associated ancillary services performed for a patient that are coded on the same claim and share a common date of service.

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**"Episode"** shall mean a unit of service consisting of all services coded on a claim. All services on the claim are considered to be part of the same APG visit and are not segmented into separate visits based on coded dates of service as would be the case with "visit" billing. Under episode billing, an episode shall consist of all medical visits and/or significant procedures that are provided by a hospital-based outpatient clinic, ambulatory surgery center, or an emergency department to a patient on a single date of service plus any ordered ancillaries, ordered on the date of the visit or date of the significant procedure(s), resulting from the medical visits and/or significant procedures, some of which may have been done on a different date of service from that of the medical visits and/or significant procedures. Multiple episodes coded on the same claim would not pay correctly; therefore, multiple episodes should not be coded on the same claim. The calculation of the APG payment by the APG software may be either visit based or episode based depending on the rate code used to access the APG software logic.

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**Reimbursement Methodology – Hospital Outpatient**

I. The criteria for using a procedure-based weight or the relative weight in the methodology is as follows: If a procedure-based weight is available for a particular procedure code, then the procedure-based weight is used. If a procedure-based weight is not available for a particular procedure code, then the relative weight (i.e., "APG weight") is used.

II. The initial calculation of the APG relative weights were developed using line level charges from 2005 New York Medicaid claims converted to cost using the ratio of cost to charges methodology. The line level costs were brought up to the APG level to determine the average cost of each APG.

a. The APG relative weights shall be updated at least annually. These APG and weights are set as of December 1, 2008, and are effective for specified services on and after that date. A link to t [T]he list of APG's and their relative weights is available in the APG Reimbursement Methodology - Hospital Outpatient section. [are published on the NYS Department of Health website at:

www.health.state.ny.us/health_care/medicaid/rates/apg/docs/proposed_regulations.pdf .]

[a]b. The APG relative weights shall be reweighted prospectively. The initial reweighting will be based on Medicaid claims data from the December 1, 2008 through [April] September 30, 2009[,] period. Subsequent reweightings will be based on Medicaid claims data from the most recent twelve month period and will be based on complete and accurate line level procedure and charge data and ratio of cost to charge data.

[b]c. The Department shall correct material errors of any given APG relative weight. Such corrections shall make use of benchmarking data consisting of payment information from other payers (including Medicare) reimbursing comparable services. Corrections to material errors in individual APG relative weights shall be made on a prospective basis.

III. Case mix index is an expression of the average paid APG weight for a given peer group after consolidation, packaging, and discounting. Case mix indices shall be calculated by running applicable claims data through the latest version of the APG software to determine the average final APG weight of the visits. Outlier claims or claim lines may be excluded from this calculation to assure overall accuracy of the final case mix. The initial [re]calculation of case mix indices for periods prior to January 1, 2010, will be based on Medicaid data from the December 1, [2009] 2008, through April 30, 2009[,] period. The January 1, 2010, calculation of case-mix indices shall be based on Medicaid data for the period December 1, 2008, through September 30, 2009. Subsequent [re]calculations will be based on Medicaid claims data from the most recent twelve-month period.

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IV. The APG base rates shall be updated at least annually. [The initial u] Updates for periods prior to January 1, 2010, will be based on claims data from the December 1, 2008 through April 30, 2009 period[,]. The January 1, 2010, update will be based on claims data for the period December 1, 2008, through September 30, 2009. [and s] Subsequent updates will be based on Medicaid claims data from the most recent twelve-month period, and will be based on complete and accurate billing data. APG base rates shall be rebased each time the APG relative weights are reweighted.

a. If it is determined by the Department that an APG base rate is materially incorrect, the Department shall correct that base rate prospectively so as to align aggregate reimbursement with total available funding. [APG payments shall also reflect an investment of $178 million on an annualized basis. The case mix index shall be calculated using 2005 claims data.]

V. [For the period December 1, 2008 to December 31, 2009, the] APG base rates shall initially be calculated using the total operating reimbursement for services and associated ancillaries and the associated number of visits for services moving to APG reimbursement for the period January 1, 2007 to December 31, 2007. APG payments shall also reflect an investment of $178 million on an annualized basis. A link to the allocation of all APG investments across peer groups for all periods is available in the APG Reimbursement Methodology – Hospital Outpatient section. The case mix index shall initially be calculated using 2005 claims data.

a. [For all rate periods subsequent to December 31, 2009, estimated] The calculation of total operating reimbursement for services and associated ancillaries and the [estimated] number of visits shall be calculated based on historical claims data. [The initial reestimation] The calculation for periods prior to January 1, 2010 will be based on Medicaid claims data from the December 1, 2008 through April 30, 2009 period[,]. The January 1, 2010, calculation shall be based on Medicaid claims data from the December 1, 2008, through September 30, 2009, period. [and s] Subsequent [reestimations] calculations will be based on Medicaid claims data from the most recent twelve-month period[,] and will be based on complete and accurate data.

b. The estimated case mix index shall be calculated using the appropriate version of the 3M APG software based on claims data. [The initial reestimations] The calculation for periods prior to January 1, 2009, will be based on claims data from the December 1, 2008 through April 30, 2009 period[,]. The January 1, 2010, calculation shall be based on Medicaid data for the period December 1, 2008, through September 30, 2009. [and s] Subsequent [reestimations] calculations will be based on Medicaid claims data from the most recent twelve-month period[,] and will be based on complete and accurate line level procedure and charge data and ratio of cost to charge data.

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VI. Rates for new facilities during the transition period

(1) General hospital outpatient clinics which commence operation after December 31, 2007, and prior to January 1, 2012, and for which rates computed pursuant to Public Health Law §2807(2) are not available shall have the capital cost component of their rates based on a budget as submitted by the facility and as approved by the Department and shall have the operating component of their rates computed in accordance with the following:

(2) For the period December 1, 2008 through [December 31] November 30, 2009, 75% of such rates shall reflect the historical 2007 regional average payment per visit as calculated by the Department, and 25% of such rates shall reflect APG rates as computed in accordance with this Attachment;

(3) F[f]or the period [January 1, 2010] December 1, 2009 through December 31, 2010, 50% of such rates shall reflect the historical 2007 regional average payment per visit as calculated by the Department, and 50% of such rates shall reflect APG rates as computed in accordance with this [Subpart]Attachment;

(4) F[f]or the period January 1, 2011 through December 31, 2011, 25% of such rates shall reflect the historical 2007 regional average payment per visit as calculated by the Department, and 75% of such rates shall reflect APG rates as computed in accordance with this [Subpart]Attachment;

(5) F[f]or periods on and after January 1, 2012, 100% of such rates shall reflect APG rates as computed in accordance with this [Subpart]Attachment.

(6) F[f]or the purposes of this subdivision, the historical 2007 regional average payment per visit shall mean the result of dividing the total facility specific Medicaid reimbursement paid for general hospital outpatient clinic claims paid in the 2007 calendar year in the applicable upstate or downstate region for all rate codes reflected in the APG rate-setting methodology except those specifically excluded pursuant to §86-8.10 of this Subpart, [divided] by the total visits on claims paid under such rate codes.

(7) The phase-in described in the preceding paragraphs [(2) through (5)] is also applicable to hospital-based outpatient clinics in operation prior to January 1, 2008.

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The following is an example of a sample APG base rate calculation:

| | | |
|---|---|---|
| a. | 2007 Peer Group Reimbursement | $51,000,000 |
| b. | Additional Investment | $25,000,000 |
| c. | Case Mix Index | 8.1610 |
| d. | Coding Improvement Factor | 1.05 |
| e. | 2007 Base Year Visits | 50,000 |

($51,000,000 + $25,000,000) / (8.1610 x *1.05 * 50,000) = $177.38 (Base Rate)

VII. Rates for existing facilities during the transition period

During the transition period, reimbursement for hospital based outpatient department services shall consist of a blend of each facility's average 2007 Medicaid rate and the APG calculation for that visit. The average 2007 Medicaid rate for purposes of blending is computed by dividing the amount paid in calendar year 2007 for all rate codes reflected in the APG rate setting methodology, by the total visits paid through those codes for the same time period. In the initial phase (ending [December 31] November 30, 2009) 25% of the operating payment for each visit will be based upon the APG reimbursement methodology and 75% will be based upon the provider specific average operating payment for calendar year 2007. For the period December 1, 2009, through December 31, 2010 [During 2010], the blend will be 50/50. During 2011, the blend will be 75/25. Hospital outpatient department payments will be based upon 100% of the APG operating component beginning on January 1, 2012. Both the emergency department and ambulatory surgery services will move to 100% APG payment upon implementation with no transition period. [Per the enabling statute, as new services the Education APGs, and the Extended Hours APGs are not subject to the blend requirement.

Effective for dates of service on and after September 1, 2009, smoking cessation counseling services provided to pregnant women on any day of her pregnancy, during a medical visit provided by a general hospital outpatient department shall be reimbursed entirely on the APG methodology.] A link to a list of APGs that are not subject to the blend is available in the APG Reimbursement Methodology – Hospital Outpatient section.

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[Effective September 1, 2009, immunization services provided in a general hospital outpatient department, when no other medical services are provided during that patient visit, shall be reimbursed entirely on the APG methodology.]

Effective for dates of service on and after January 1, 2009, payments to general hospital outpatient departments for the following services shall be based on fees or rates established by the Department of Health: (1) wheelchair evaluations, (2) eyeglass dispensing, and (3) individual psychotherapy services provided by licensed social workers to persons under the age of 21, and to persons requiring such services as a result of or related to pregnancy or giving birth. Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. The agency's alternative payment fee schedule rates for the services listed in this paragraph were set September 1, 2009 and are effective for services provided on or after that date. A link to the APG alternative rates for all periods is available in the APG Reimbursement Methodology – Hospital Outpatient section.[The rates are published on the Department of Health web-site at the following link:

http://www.health.ny.gov/health_care/medicaid/rates/apg/docs/apg_alternative_payment_fee_schedule.pdf]

VIII. Rates for services provided in hospital outpatient facilities located outside of New York State shall be as follows:

- APG rates in effect for similar services for providers located in the downstate region of New York State shall apply with regard to services provided by out-of-state providers located in the New Jersey counties of Sussex, Passaic, Bergen, Hudson, Essex, Union, Middlesex and Monmouth; in the Pennsylvania county of Pike; and in the Connecticut counties of Fairfield and Litchfield; and rates in effect for similar services for providers located in the upstate region of New York State shall apply with regard to all other out-of-state providers.

- In the event the Department determines that an out-of-state provider is providing services which are not available within New York State, the Department may negotiate payment rates and conditions with such a provider up to but not in excess of the provider's usual and customary charges. Prior approval by the Department shall be required with regard to services provided by such providers.

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- For APG reimbursement to out-of-state hospitals, the downstate region of New York State shall consist of the New York counties of Bronx, New York, Kings, Queens, Richmond, Nassau, Suffolk, Westchester, Rockland, Orange, Putnam and Dutchess, and the upstate region of New York State shall consist of all other New York counties.